Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH LLC
5445 LA SIERRA DR #204
DALLAS TX 75231

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TIG INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-7410-01

MFDR Date Received

APRIL 2, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the preauthorization letters (IRO Case #14830, #7118826 & #71191161-1), EOBs, claims, and documentation. The patient was referred for the Chronic Pain Management Program. We provided the services and were denied per EOB entitlement to benefits, not finally adjudicated. The treatment that was provided is part of his compensable injury to his lower back that we sustained on 11/19/01. Also, COT code 97799 CPCA was preauthorized, #IRO Case #14830, #71188262-1 & #71191161-1… In summary, it is our position that Risk Enterprise Management has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to [injured worker]. "

Amount in Dispute: $11,362.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOBs regarding the treatment s issue raise underlying issues of causal relation. In particular, the EOBs indicate that the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2008 through October 2, 2008 and November 10, 2008 through January 19, 2009	CPT Code 97799-CP-CA	$11,362.50	$11,362.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for Workers Compensation Specific Services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorized services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 45 – Contract/Legislated Fee Arrangement Exceeded.
- W1 – Workers' Compensation State Fee Schedule Adj.
- W11 – Entitlement to benefits. Not finally adjudicated.
- 50 – Services not Deemed 'Medically Necessary' by payer.
- T13 – Med necessity denial.
- B13 – Payment for service may have been previously paid.
- R01 – Duplicate billing.
- 97A – Provider appeal.
- W4 – No additional payment allowed after review.
- 080 – Denied per carrier.

Issues

1. Were the services rendered to the compensable injury?
2. Did the requestor have a contractual agreement with the carrier?
3. Did the requestor obtain preauthorization for the Chronic Pain Management program?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the services using denial reason code W11 – "Entitlement to benefits. Not finally adjudicated." Review of the submitted bills indicates the diagnosis documented was 847.2 – Lumbar Strain-Sprain, which is the compensable injury. Therefore the denial reason is not support and the disputed services will be reviewed for payment in accordance with 28 Texas Administrative Code §134.204(h)(5)(B).
    - The requestor billed a total of 79 hours for CPT Code 97799-CP-CA for dates of service September 11, 2008 through September 29, 2008 and December 24, 2008 through January 19, 2009. The maximum allowable reimbursement for these dates of service is $125.00 x 79.00 = $9,875.00; therefore, reimbursement of $9,875.00 is due.
2. The insurance carrier reduced the August 26, 2008 and October 2, 2008 services with reason code 45 – "Contract/Legislated Fee Arrangement Exceeded.". Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with 28 Texas Administrative Code §134.204(h)(5)(B).
    - The requestor billed 4.5 hours of CPT Code 97799-CP-CA. The maximum allowable reimbursement for this date of service is $125.00 x 4.5 hours = $562.50 - $450.00 (carrier reimbursement); therefore, additional reimbursement of $112.50 is due.
    - The requestor billed 5 hours of CPT Code 97799-CP-CA. The maximum allowable reimbursement for this date of service is $125.00 x 5 hours = $625.00 - $562.50 (carrier reimbursement); therefore, additional reimbursement of $62.50 is due.
3. The insurance carrier denied dates of service November 10, 2008 and November 12, 2008 using denial codes 50 – "Services not Deemed 'Medically Necessary' by payer" and T13 – "Med necessity denial."In accordance with 28 Texas Administrative Code §134.600(c), effective May 2, 2006, the carrier is liable for all reasonable and necessary medical costs relating to the health care:(1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or (D) when ordered by the Commissioner; or (2) per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section. The requestor submitted an Independent Review Organization decision in which the reviewer found that medical necessity exists for the chronic pain management program; 10 sessions were authorized. The requestor also submitted preauthorization determinations # 71188262-1, dated October 10, 2008 which approved 10 sessions of the chronic pain management program starting on October 9, 2009 and ending

November 9, 2008 and preauthorization determination # 71191161-1, dated December 22, 2008, starting December 19, 2008 and ending January 19, 2009. The denial reasons are not supported and the disputed dates of service will be review in accordance with 28 Texas Administrative Code §134.204(h)(5)(B). Review of the chronic pain management notes support reimbursement.

- On November 10, 2008 the requestor billed 6 hours of CPT Code 97799-CP-CA. The maximum allowable reimbursement for this date of service is $125.00 x 6 hours = $750.00; therefore, reimbursement of $750.00 is due.
- On November 12, 2008 the requestor billed 4.5 hours of CPT Code 97799-CP-CA. The maximum allowable reimbursement for this date of service is $125.00 x 4.5 hours = $562.50; therefore, reimbursement of $5622.50 is due.

4. Review of the submitted documentation finds that additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $11,362.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $11,362.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 19, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.